



**HIPAA Release Form
Authorization to Disclose Health Information**

Participant Information

Participant Name: _____

Employer: _____

Social Security or Tri-Star Account #: _____

Authorization

I, _____, hereby authorize Tri-Star Systems to disclose specific health information from the records of the above named participant to: (Recipient Name/Relationship/Phone)

Specific information to be disclosed: All Account Information

All Tri-Star Account Information

Account Information Limited to: _____

I understand that:

- The information used or disclosed may be subject to re-disclosure by the person or call of persons or facility receiving it, and would no longer be protected by federal policy regulations
- This authorization is voluntary and I may refuse to sign it
- This authorization is valid until revoked and I must revoke this authorization by notifying Tri-Star Systems in writing. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
- No financial or in-kind compensation or remuneration is received in exchange for using or disclosing this information.
- Any re-disclosure of information disclosed to the participant by the participant is no longer protected by federal privacy laws.

Signature of Participant

Date

Signature of Representative & Relationship to Participant

Date

Revocation Section

This authorization was revoked on _____

Date

Signature of Participant or Representative

**Fax completed form to:
314.985.0277 or 800.818.0829**